

**Geriatrics and Gerontology Advisory Committee (GGAC) Meeting  
September 27-28, 2018  
Meeting Minutes**

**Attendees:**

**Committee Members**

Admiral Clyde Marsh, Committee Chair  
Harvey Cohen, MD  
Judith Beizer, PharmD  
Joseph Ouslander, MD  
Barbara Smith, PhD  
David Gifford, MD, MPH  
Kathleen Welsh-Bohmer, PhD, ABPP  
Jennie Chin-Hansen, MS, RN, FAAN  
Nora O'Brien-Suric, PhD  
Shurhonda Love

**Ex-Officio Members**

Lori Gerhard

**Staff**

Marianne Shaughnessy, PhD  
Stephen Thielke, MD  
Sherri DeLoof, LMSW  
Alejandra Paulovich, DFO

**Guests**

Susan Cooley, PhD

Mary Ward  
Latonya Small, PhD  
Jennifer McKenzie  
Samantha Solimeo

**Speakers**

George Fuller, MD  
Ellen Bradley  
Lisa Minor, RN, MSSL  
Joseph Francis, MD  
Benjamin Kligler, MD  
Richard Stone, MD  
Bruce Kinosian, MD  
Jim Rudolph, MD  
Kevin Foley  
Nicholas Page  
Jo Ann Parker, MHSA  
Valerie Delanko, RDN, LDN, CPHQ  
Latrice Vinson, PhD  
Thomas O'Toole, MD  
Nicole Katikos, MHA

**Call to Order, Admin Remarks, Housekeeping, and Introductions**

Ms. Alejandra Paulovich, Designated Federal Officer (DFO), GGAC, opened the meeting with a set of introductory remarks. During her remarks, Ms. Paulovich informed members and guests of GGAC's statutory charge and meeting objective to advise the SECVA on all matters pertaining to geriatrics and gerontology. Ms. Paulovich also identified the date public notice of the meeting was given, and, reviewed presentation slides and read ahead material. and covered general housekeeping items.

**Admiral Clyde Marsh**

**Welcome Remarks from the Chair**

Admiral Clyde Marsh welcomed members and guests to the meeting. The Chair went over the agenda, introduced himself, and had committee members and guests introduce themselves.

**George Fuller, MD**

**GEC Leadership**

Dr. George Fuller, Executive Director, Geriatrics and Extended Care, thanked members for their service on the committee. He apologized for not being able to make it to the meeting in person. Dr. Fuller thanked Dr. Stephen Thielke for filling in as the Co-Director for Innovation, Diffusion, and Communication since

May of 2018. Dr. Fuller notified members that Dr. Thielke's detail with the GEC office ends on September 30<sup>th</sup> and Dr. Marianne Shaughnessy will step into this role upon his departure.

Dr. Fuller provided a brief background of his career. Dr. Fuller is a Veteran with 42 years of public service and has been with the VA since 2005. He did a two-year geriatric fellowship at the American Lake VA in Tacoma, Washington under their GRECC. He has been a Chief for Primary Care and Specialty Acute Care, Chief of Staff, Chief Medical Officer of VISN 1, and Deputy Chief of Staff of VA Connecticut (Level 1A affiliate of Yale). Dr. Fuller has been with GEC since the beginning of August 2018. His academic appointments include Uniformed Services University of the Health Sciences, Yale, and UCONN.

Dr. Fuller is very concerned about VHA realignment and the potential loss of expertise in the office of GEC. An organizational chart for GEC was approved in April 2018, however, Dr. Fuller is being asked to revise the current chart. GEC currently has 31.7 authorized FTE employees: 7 FTE are vacant, 2 are on detail, and several part time staff. GEC also has some very important positions vacant. Dr. Fuller does not have leadership approval to fill vacancies at this time. GEC can no longer use MOUs to fill vacancies. GEC can use details, however, details are not good for leadership positions. Dr. Fuller's focus is to try to get an organizational chart approved so he can start filling important vacancies. There is currently a lot of pressure to reduce FTE at VACO during this reorganization.

Dr. Fuller introduced his intentions of establishing a new GRECC with a focus on Long Term Care. He emphasized that VA needs a dedicated asset to research, education, and clinical work that attracts people who are interested in focusing on long term care. Lori Gerhard commended Dr. Fuller for his vision and effort on this and emphasized that the Administration for Community Living (ACL) will stand ready to offer support.

Dr. Fuller believes that the current CLC issue is a product of several decades of neglect. Dr. Fuller has not seen a lot of attention paid to long term care over the course of his career in the VA. He stated that it is very difficult to get members of Congress to understand that the current state of CLC's cannot be turned around as quickly as they might like. Further, VACO Leadership is also expecting the CLC scores to improve quickly. Dr. Fuller is hoping that in 12-18 months there will be a system wide visual improvement.

Dr. Ouslander commented that he does not believe that the CLC ratings are a function of the real quality of care that is provided. He believes it is an artifact of many other things, including the fact that many CLCs are enriched with hospice patients. VA cannot do a comparison quality measurement on a skilled nursing population where a significant number are in the hospice program. Dr. Ouslander suggested that leadership initiate a GRECC, or at least from a component of an existing GRECC, to establish a work group that can drill down on the CLC quality measures. Dr. Harvey Cohen also voiced support for the establishment of a workgroup and emphasized the importance of including consultants from outside VA to establish more weight in the ultimate recommendations.

Dr. Fuller mentioned the current leadership's focus on the Office of Community Care (OCC). OCC offices are expanding in size at every medical facility. There is a mandate for these medical centers to roll out this program. Most of the services paid for outside of VA, VA doesn't provide itself. Dr. Fuller indicated that VA doesn't have good quality metrics on community provided care, but that this is something VA is looking toward improving in the future.

There are also challenges navigating VA's financial system, which has been challenging the GEC office. Budgetary restraints have left GEC with several unfunded mandates, including the State Veterans Home

Survey, which is required by law. Other GEC initiatives are under threat of a lack of funding as well, and it remains unclear what the funding will look like in the coming fiscal year.

The Chairman thanked Dr. Fuller for his time and commented that the committee is very appreciative for his move to push Dr. Shaughnessy forward in the Acting role for the Director, Innovation, Diffusion and Communication position. The Chair also encouraged Dr. Fuller to remain engaged with the committee and welcomed dialogue and collaboration with him anytime.

### **Ellen Bradley**

#### **Veterans Equitable Resource Allocation (VERA)**

Ms. Ellen Bradley from VA's office of Allocation Resource Center (ARC) discussed how patients get classified when they are receiving care and how they are funded.

The estimated budget for FY19 will be finalized in the coming weeks. Once the budget is known, the budget will be divided into two components. The first is Specific Purpose Funding (SP) – a majority of this funding is earmarked and also includes Medical Community Care and Choice funding (last year it was \$25 billion). SP funding used to account for 20% of VA budget, however, it now accounts for 34%. This jump is directly attributed to the non-VA care funds used for community care. The remaining budget falls under General Purpose (GP) funds. Ms. Bradley anticipates that there will be \$48.6 billion dollars for FY19 (this number is not final). GP funds make up 66% of the entire VA budget.

Once Ms. Bradley's office knows what the budget is going to be, her office starts completing the VERA model. Ninety percent or more of the funds that are put through the VERA model are directly attributed to patient care. The transition to the VERA model is to ensure that dollars are flowing to where patients are located.

The Medical Center Allocation System (MCAS) determines how much funding is going to each facility within each VISN. The VERA Patient Classification system is used to classify all patients into hierarchically arranged classes based on total care received during a fiscal year (FY). Meaning, every patient that receives care, that's either provided by or paid for by VA, are put into a single class. VHA has a great deal of expenditures now for private sector care, and when VA pays the bills, the workload is also included in the VERA model, however, sometimes these payments can be captured in a subsequent FY.

The classification system organizes all patient data. VERA uses the Pro-Rated Patient (PRP) methodology to account for patient care and MCAS uses Patient Weighted Work (PWW) for distributing patient care funds.

Patient costs are used to apportion the patient workload to location of care. For example: a Veteran who has all of his/her care provided at a single facility will have a PRP equal to 1.0 at that facility. A Veteran with care in more than one location has shared care. The care is pro-rated based to each location based on the proportionate distribution of cost. The PRP (although distributed) does not exceed 1.0. The VERA budget is based on the prices in the VERA model, multiplied by PRP. If a facility is losing patient workload, they are likely losing VERA funding as well. In order to increasing VERA funding, it would require growing VERA-funded workload.

The VERA model is carried forward from one year to the next. Every January and February, an email is sent out by the VHA CFO requesting recommendations for changes. Several recommendations are received each year and these recommendations are reviewed and presented to the leadership committee. This is how changes are made to the VERA model. This system is exclusive to VA.

Ms. Bradley reviewed the VERA model's Hierarchy Chart (HC). This chart categorizes all patients based on workload. Most patients receiving geriatric services are class number 64 on the HC and funded under price group 10. This group identifies patients who have spent at least 90 days in a VA CLC. These do not need to be continuous days. This calculation is based off of the total number of days during the FY (Oct 1 – Sept 30). A long-term care stay is funded at about \$212,000 per patient. Ms. Bradley stressed that one of the costliest things VHA does for any patient is admit them into a CLC unit. The number of patients in this group last year were approximately 10,000 with an average cost of \$275,000 per patient.

There were several comments about whether or not the 90-day minimum would change to be more analogous to the private sector. Ms. Bradley indicated that any recommendation could be submitted and considered for changes to the model. Dr. Gifford cautioned making any changes, since the definition of short and long stay, provided by the Centers for Medicare and Medicaid (CMS) are not straight forward. Ms. Bradley commented that if a proposal was submitted to make a change, research would be conducted before any changes would be adopted.

Ms. Bradley reviewed several other classes and price groups in the hierarchy chart including: transplant patients, polytrauma patient units, short stay class, and the critically ill class. Ms. Bradley also stressed that there are some teeth in the VERA system to ensure (short term vs long stay class) Resource Utilization Group (RUG) scores are being completed in a timely manner. If RUG scores are not completed, a patient will be defaulted to a lower price group. So, there is great incentive for completing RUG scores.

The majority of patients are classified as Basic Care. Only 6% are classified under the complex care class. Although only 6% fall under this class, this group consumes a considerable amount of the resources.

The High Cost threshold is determined each fiscal year by the approximate 1% most costly patients in the VHA system. VISNs receive funds equal to the amount in excess of the established high cost threshold. The intent is to hold the units that care for the costliest patients in the system. This population typically has a high volume of inpatient Bed Days of Care (BDOC). The standard threshold is \$122,000 and the Long Stay CLC threshold is \$311,000. Costs that exceed the threshold are allocated using patient specific PRP.

The patient receives one price in the VERA model and the VISN the receives the money. The VERA model determines the amount of money that will go to the VISN. The VISN is obligated to distribute the money. If they decide to make any changes to how the money is distributed, the VISN Director is required to provide a justification in the MCAS system.

Ms. Bradley wrapped up her presentation by reviewing how VERA applies to research funding. Research support is associated with research grants. This past year, preliminary reports indicate that there are going to be over \$618 million dollars associated with research support. The process for allocating this funding is based on the amount of research grant dollars. ARC reaches out to the research departments and research development systems to get data on all of the research grants. The grants are then weighted based on the source of the funding. If a grant is VA funding, a 100% credit is applied. If a grant is non-VA funded and peer reviewed, a 75% credit is applied, if a grant is not VA funded or peer reviewed, a 25% credit is applied. The total discounted grant dollars are then divided into the estimated budget for FY19 (which is anticipated to be \$618 million), and receive \$0.60 for each discounted grant dollar. All of this information is available on the ARC website.

Ms. Gerhard mentioned the issue of purchased care claims not being paid in a timely manner. She asked how non-paid invoices are captured into the VERA model. Ms. Bradley clarified that purchased care in the community is counted after it is paid.

Ms. Gerhard followed up asking what percentage of patients that are reviewed actually have RUG scores. Ms. Bradley did not have that information available, however, she will follow up and get that information to the committee.

**Joe Francis, MD and Lisa Minor RN, MSSL  
CLC Compare**

Dr. Joe Francis from the Office of Reporting Analytics and Performance Deployment (RAPID) and Ms. Lisa Minor, RN, MSSL met with committee members to provide background and an update on the recent CLC compare report.

VA is using CLC Compare at the request of VHA Administration, SECVA, and Congress. This is VA's first attempt at following CMS's 5 STAR methodology. Strategic Analytics for Improvement and Learning (SAIL) is an internal 5 star rating largely based off of quintiles of aggregated performance for VA hospitals and clinics. For CLC's, VA has decided to make the comparison with the community. It is a work in progress. VA is working with experts, including CMS contractors, to help VA understand how they run their codes and to better understand some of the nuances. In the quality domain, VA only has 11 of the 15 CMS measures currently available. Dr. Francis is gaining a better understanding how VA is doing with the claim based measures. He reviewed the CLC Quality metrics compared to CMS nursing homes on short stay residents vs long stay residents. There are certain areas that VA's hospice care fares better since they do handle a lot of hospice care. VA is trying to gauge how Medicare measures quality certifies facilities, and captures comorbidities that they use in their adjustment. VA has never use this method before and there are many nuances to understand.

Dr. Francis believes that VA could do better on the survey. He believes VA created some confusion within itself by having two survey processes for many years: Joint Commission (hospital, ambulatory, labs, and CLCs) and the Long-Term Care Institute (LTCI) Process. Joint Commission has a gravitational mindset towards acute care which is very different from the cultural transformation that is needed in CLCs. About two years ago a decision was made to put Joint Commission aside for CLCs and to go with the CMS unannounced survey which occurs every year. Because of this, VA is playing catch up. VA has improved markedly, however, there is still room for improvement.

VA has a commitment to evidence based practice. VA needs to make more investments in non-pharmacological management of behavioral disturbances and non-pharmacological management of pain. Pain is another area where VA compares less favorably. There is a secondary gain element with pain measure in VA. Veterans often indicate a higher pain score because they are fearful of losing their VA benefits. While it's important not to question a patient's pain level, providers should use caution when prescribing opiates.

Because VA is following CMS methodology, VA uses a state distribution of scores for each of VA's CLCs. There has been debate on whether or not VA should move towards a national distribution of results. This model can be constructed; however, it makes very little change in the aggregate – in fact, VA would lose more stars than gain, largely due to shrinkage issues and estimation. It is difficult for VA to justify using a different approach than Medicare.

Press releases can affect where the most attention and resources are diverted to. There is a tendency to worry the most about a hospital. Even if you make everything better today, you won't see the results for about 3 years. This is because the measures are highly aggregated. The quality measures have a rolling 12-month average and the survey scores have a rolling 3-year average. A bad survey can make a facility look like a bad performer for the following two years.

Once a year, Medicare anchors the star rating through a once a year unannounced survey. The star rating is based on the State's score. VHA CLC staffing tends to be good. VA is 5 stars at all of the sites for staffing, presuming that they keep up with Managerial Cost Accounting (MCA), where they keep track of the RUG scores and the payroll.

A 5-star rating in number may not equate to 5-stars in effectiveness if you do not use your staff effectively. Ms. Minor mentioned that one of the major challenges in the CLCs is that the field of long term care is not attractive for students coming out of school. Even though it is a specialty field, they would rather go into other specialty areas such as acute care or ICU. Another issue for staffing effectiveness is the lay out of the CLCs as the nursing stations are not optimal for promoting staff effectiveness. Lastly, in terms of filling vacancies, it can take 4-6 months to bring an RN on board across the system.

In the Mission Act, VA is required to do an assessment of all capital assets, including CLCs long term care. The intent is to look at where VA's CLC beds are, assess if they are appropriate for the population, and determine if they need more or less in certain locations. This is a positive, yet resource intensive, effort. Most of VA's CLCs are footprinted inside the medical centers. A lot of the medical centers were built as far back as 1920's – so much of the infrastructure and layout is outdated. Section 104 of the Mission Act requires VA to compare itself to the private sector utilizing private sector metrics. In section 109 it states, if you don't favor favorably, you will outsource the care and then devote resources to fixing the problem. Dr. Francis believes this gives VA some leeway with the constraints endured under the Millennium bill which made it more difficult to flex bed numbers up or down.

Dr. Francis believes this is an opportunity to leverage the attention, without overreacting or underacting, to what the stars are saying.

### **Benjamin Kligler, MD** **VA Whole Health Initiative**

Dr. Benjamin Kligler discussed the Whole Health Initiative with committee members. The initiative embodies a 3-prong approach:

1. **The Pathway:** In a partnership with health coaches and trained peers, Veterans will explore their mission, aspiration, and purpose, and begin their overarching personal health plan based on what matters most to them in their life.
2. **Well-being Programs:** With a focus on self-care, skill building and support, these programs will offer access to Complementary and Integrative Health (CIH) modalities and self-care skills, depending on the needs and focus of the individual Veteran. Services will include approaches such as stress reduction, yoga, tai chi, mindfulness, nutrition, acupuncture, manual therapies, and health coaching.
3. **Whole Health Clinical Care:** VA will maintain the commitment to cutting edge treatment and disease management, but will re-orient the process of care around the Veteran's meaning, aspiration, and purpose, and what matters most to them in their life. Whole Health-trained clinicians will use the Veteran's Personal Health Plan as the guide for shared decision-making about treatment priorities.

Several benefits have been identified with the whole health approach, including: improved immediate access by creating new Whole Health portals in VA that do not bottle neck primary care; improved long term access by increasing engagement and self-care, reducing clinical demand; improved coordination with community care by establishing a Veteran-driven Personal Health Plan; improved Veteran satisfaction and loyalty, by offering a true partnership across time and eliminating fragmentation; improved health outcomes and reduced costs, by redesigning what healthcare to invest in the Veteran's Whole Health; rebuilding trust in VA by doing the right thing for our Veterans; and creating the future of healthcare for our Veterans and for our Nation.

There is pressure and momentum on the concept of distinguishing VA. Providing a truly integrated approach to whole person care that incorporates what is important to the Veteran, complimentary health services, and clinicians that understand where the Veteran is coming from is something that the private sector cannot do for many Veterans, and that VA can do – this is a very unique initiative.

Whole Health was built upon initiatives that have been in place at VA for a long time, including patient centered care and the concept of proactive patient driven care. Since 2010 there have been several small innovation pilots across the country. In FY15, 16, 17 VA began funding design sites.

The turning point came in FY18 in part related to the Comprehensive Addiction and Recovery Act of 2016 (S.524). Sec. 933 mandated a large-scale demonstration project in at least 15 diverse sites geographically around the country for a 3-year duration to look at what the impact would be of expanding access of complimentary integrated health and wellness based programs. This approach was put under the rubric of whole health.

When the mandate came out, the Network Directors and Medical Center Directors as a group decided to be supportive of the initiative and Whole Health flagship sites were established in all 18 VISNs. The launch began in October 2017. The goal of the program is to implement all three parts of the Whole Health System and touch at least 30 percent of the Veterans being seen at each respective facility, with some aspect of whole health care, and to also participate in the assessment of the outcomes. These flagships have an opportunity to push forward innovative approaches.

The study outcomes will look at patient reported health outcomes, clinical outcomes, and Veteran experience and satisfaction, implementation, cost and utilization, and healthcare workforce (including engagement and burnout).

Dr. Cohen emphasized that the outcome measure for a patient should not be Veteran satisfaction, but rather the patient's goals. Dr. Kligler agreed and had more to share, but in the interest of time, it was decided the group would be connected to Dr. Kligler through Ms. Paulovich.

Dr. Kligler's team is piloting a new program to have a well-being vital sign installed. There are two questions that have been used in the UK for a national happiness survey that are used to examine well-being. Dr. Kligler is open to any kind of feedback or connections related to this.

Dr. Cohen commented that the VA conducted a Goals of Care assessment on the Geriatric Evaluation & Management (GEM) units about 30 years ago. He emphasized that a Veteran's goal of care may not necessarily equate to well-being as defined by their terms. The view of success may need to be modified.

Dr. Kligler is open to continued dialogue with the committee. He indicated that he wasn't sure how the committee could help, but that his group needs a way to help motivate or galvanize several sites out in the field, whether they are flagships or not, that have a leadership empowered partner who wants to help move this initiative forward.

Dr. Thielke mentioned that he had encouraged the GRECCs to work with their Whole Health team for collaboration opportunities.

The Chair commented that this is an initiative GGAC has an interest in and can support, but cautioned that GGAC could not drive the needle. The Chair also mentioned that members would be sure to make mention of the program while they are out conducting their site visits. Others commented that this goes beyond pushing through the GRECCs and that mention could be made in the report that goes to SECVA.

**Richard Stone, MD**  
**Executive in Charge**  
**Veterans Health Administration**

Dr. Richard Stone met with members and discussed his new role and top priorities as the Executive in Charge for the Veterans Health Administration. Dr. Stone is working on the GGAC's 2017 recommendations and plans to clear a response back to GGAC from the Department.

Dr. Stone's top 3 priorities are:

1. Restoring trust in the people of VA. This means reliability - hiring liability and zero harm. He encouraged GGAC members to check out the Air Force Trusted Care efforts which is a campaign he expects VA to model to restore trust in the system.
2. Becoming a learning organization. Dr. Stone believes VA is too slow to implement scientific advances, propagate best practices, and is too vertically integrated. He believes effective complex geographically dispersed health care organizations are horizontally integrated across service lines and across integrated project/care teams and they talk to each other very quickly.
3. Modernizing. Dr. Stone's centerpiece of modernizing is the Electronic Health Record (EHR). He indicated that 95 percent of the business processes of VHA are aligned/connected to the EHR. One of the first issues he wants to tackle is VA's fractured supply chain that is costing the American tax payer nearly 2 billion dollars every year. He also emphasized that this supply chain will need to connect to the EHR so that modernization is getting Veterans what they need and making sure VA serves them appropriately.

The Chair asked Dr. Stone about the hiring freeze at VA and Dr. Stone clarified that he recently unblocked the hiring freeze. VA Central Office has about 2,265 employees with about 300 vacancies.

Dr. Gifford asked Dr. Stone about the Whole Health program and how it fits in with his priorities. Dr. Stone responded that Whole Health is on his radar and he believes it is a great program. Dr. Stone is interested in hearing GGAC's opinions on how the approach can be integrated within the field of geriatrics.

**Bruce Kinoshian, MD**  
**Geriatrics and Extended Care Data Analysis Center (GEC DAC)**

Dr. Bruce Kinoshian from the Office of Geriatrics and Extended Care Data Analysis Center (GEC DAC) presented data based from a request that was received from GGAC's Spring meeting. Dr. Kinoshian set out to address the cost of the GEC cohort, their complexity, and the group's growth projection.

The GEC cohort is predominately over the age of 65, with 20 percent who are under 65. The individuals who are over 65 have the same distribution of diseases as all Veterans over 65, except for dementia, which is much more prevalent in the GEC cohort.

GEC manages Veterans who have higher costs than other groups. The GEC budget is about 10 percent of the overall VA budget and serves about 6 percent of Veterans that use VA. These Veterans drive about 30 percent of VA resources. GEC is highly leveraged in terms of its impact on sustainability of the organization.

GEC manages Veterans who have greater needs than other Veteran groups. Using a variety measures of frailty, almost half of GEC Veterans are frail or very frail. Looking at the non- GEC group of Veterans, only about 9 percent of those Veterans are considered frail. The GEC six percent that drives 30 percent of VA resources represents 35% of all frail or very frail Veterans in the system. This has increased from 29 percent over the last decade. Since 2007, the share of GEC Veterans who are frail or very frail has increased by about 21 percent. The GEC cohort in 2007 served about 4 percent of VA users, and about 29 percent of those were frail or very frail. In 2016 this number was at 6 percent and at about 35 percent of those were frail or very frail.

Veterans using GEC services are going to grow over the next decade (primarily driven by Vietnam cohort). GEC services provisions are expected to grow 77 percent, and there will also be a 67 percent growth in Veterans who have a mandatory benefit for long term institutionalization. While there is a declining number of Veterans there is an increased number of Veterans who have an increased reliance on VA. There is a concurrent rising number of Priority 1A Veterans, for whom VA has an obligation to provide nursing home care. This is going to drive service decisions over the next decade.

GEC costs are dominated by institutional costs and CLCs – this represents nearly half of the total GEC budget. There has also been substantial growth in the use of home health aide, personal care services, and purchased skilled care. Projections show that the biggest increase in users is going to be among users aged 75-84 and the largest increases in services are going to be in home and community based services costs and community nursing home costs. Over the next 12 years costs for community based services is going to more than double and those for community nursing homes are expected to grow at just under 100 percent.

GEC faces rising populations, increased demand, and obligation to provide long term institutionalization for highly service connected Veterans with limited resources.

Dr. Kinoshian encouraged members to follow up with any questions and he would follow up with responses and data as needed.

### **Geriatrics and Extended Care Program Staff**

GGAC members met with GEC staff to discuss GEC programs, updates, and to engage in general discussion.

Dr. Jim Rudolph provides administrative oversight over GEC DAC. GEC DAC has built a library of incredible resources for VA. Dr. Rudolph's office has been trying to get a lot of this information and data to decision makers. Dr. Rudolph also oversees the GEC survey. Twice a decade a survey goes out to all facilities to identify the GEC programs that they have and offer to Veterans. This information creates a

directory of the GEC services provided across the country at VA facilities. Dr. Rudolph also works on the Choose Home Initiative and is working on Choose Home, Community Nursing, and Delirium dashboards.

Mr. Kevin Foley works in the Office of Home Community Based Services. His office handles Home Based Primary Care, Medical Foster Home, and Community Residential Care. T21 programs are also led by the team in this group, which includes: VA Adult Day Health Care, Foster Home Rural Expansion, and Home Based Primary Care for Rural Expansion. One of the major challenges is that not all of these programs are available everywhere and if you don't have a program, you don't have a waitlist – so it is difficult to measure demand.

Mr. Nicholas Page works with Mr. Dan Schoeps who is the Director for Purchased Long Term Services and Supports. His office handles all purchased care and works directly with the Office of Community Care on issues related to claims, policy, education, etc. Mr. Page indicated that a contract is expected to be awarded within the next year that will replace Tri West and Health Net as VA Choice contractors, including those services that are purchased for geriatric care.

Ms. Jo Anne Parker, MHSA is a National Program Manager for the State Veteran Home (SVH) Program which encompasses three levels of care: Nursing Home, Adult Day Health Care and Domiciliary Care. They also cross over with several programs. The Construction Grant Program furnishes 65% of the construction cost of new SVHs. After a home is constructed, Ms. Parker's office recognizes the home and follows up with surveys to ensure the home is following Federal regulations. The Community Care Program handles per diem that is paid to the SVH. VA currently supports 156 SVHs. Ms. Parker's office reviews survey reports, records survey reports, and when there is a recognition or call for survey, organize a site visit teams. She also works closely with the VISN and Medical Center Director (MCD) of jurisdiction associated with the SVH and National Association of State Veterans Homes.

Ms. Valerie Delanko, RDN, LDN, CPHQ is a National Program Manager for the State Veteran Home Program for Quality and Oversight. She works with the Office of Representatives, VISN, and the MCDs of jurisdiction in regard to what is external review, how regulations are interpreted, and how to rate compliance. She also ensures that citations are clear, identifies what is required for corrective action and evidence of compliance to close out surveys. Her office recently brought together CLCs and SVHs to participate in a series of classes on falls prevention. Ms. Delanko also works on identifying and sharing best practices in the VA that can help the SVHs.

Dr. Latrice Vinson is a former Health Aging and Policy Fellow with GEC. She is currently in the GEC office through a collaboration with the Office of Mental Health in Suicide Prevention and the VISN 5 MIRECC. Dr. Vinson Co-Directs the Care for Patients with Complex Problems Program (CP<sup>2</sup>) which focuses on adjusting the needs of Veterans who have co-morbid medical, mental health, and cognitive impairment, who also have behaviors that are disruptive and distressing for care. There are three components to this program: 1.) Implementing and disseminating promising practices that address the needs of this population; 2.) Learning collaborative. There is a National webinar that runs monthly and on the VA Pulse site that provide learning opportunities and collaboration; 3.) Centralized Technical Assistant and Coordination Team (CTAC). The first model is rolling out and based on a behavioral recovery outreach team that focuses on transitioning Veterans from an inpatient unit to less costly and more appropriate outpatient or community settings. They are currently partnered with VISN 23, where the model began, in Central Iowa where they implemented a regional dissemination of the program. The outcomes have shown decreased costs, lengths of stay, and a 9% reduction in behavior readmissions into the hospital. The team is currently working on a plan to roll this out nationwide.

Dr. Marianne Shaughnessy is currently the Director of Policy, Practice and Population Health Integration and the new Acting Director for Innovation, Diffusion, and Communication (Vice Shay). Dr. Shaughnessy mentioned a focus on dementia and delirium. She mentioned that every hospital and outpatient setting has an issue with these geriatric syndromes and it's an area that needs to be addressed. Her team is currently working on getting some clear guidance out to the field on whether or not VA will endorse inpatient screenings. Additionally, dementia specific questions have been added to the survey GEC DAC sends out twice a decade to identify the geriatric programs available through VA nationwide. Several GRECCs have a focus in this area, including the Cleveland and Gainesville GRECCs who are active with work in delirium. Dr. Shaughnessy partnered with the Office Nursing Services to get a membership with GEC to join the National Hartford Center for Geriatric Nursing Excellence. The intent was to collaborate with them and develop a curriculum for new nurse managers and to give them experience in a VA setting. Through these collaborations, they applied for a grant to get the initiative started and were awarded a \$100k grant. The plan is to get VA and Hartford staff to develop an 18-hour curriculum which will be delivered over a 6-month period. There will also be additional projects that will bring it to a 12-month total curriculum. This is currently in a pilot phase, however, there will be more to come on this in the future.

Dr. Cohen asked what specifically leadership didn't like about the organization of the GEC organizational chart. Dr. Shaughnessy commented that leadership wants GEC to look like the Office of Surgery, however, GEC does not have the same kind of standard structured alignment found in the field, so this expectation is challenging. Dr. Fuller is working on the new GEC Organizational Chart. Dr. Gifford asked how the GEC new Org Chart will fit in with Dr. Stone's vision toward horizontal organization and integration. Dr. Shaughnessy commented that she'd bring it to Dr. Fuller's attention since she was not sure.

Dr. Ouslander asked how SVHs are rated on quality compared to the CLCs. Ms. Delanko clarified that the SVH program is a grant program and they are required to meet the Federal regulations under 38 CFR parts, 51 and 52. They somewhat mirror CMS, but they are stand-alone Federal regulations. Of 156 SVH, only 60% are CMS certified.

#### **Thomas O'Toole, MD** **Choose Home Initiative**

Dr. Thomas O'Toole met with members to provide an update on the Choose Home Initiative. One of the main questions driving the initiative is trying to determine if VA can introduce non-institutional care to those highest risk Veterans with the intent of trying to delay, defer, or eliminate the need of nursing home placement. He believes this approach fits much in line with the Veteran's and their family's preference.

Over the past 12 months his team has recognized that VA has a lot of inefficiencies with how care is being managed between the community and VA. Right now, the referral process into non-institutional care programs centers around input from the PACT team. Additionally, capacity for community referrals does not really exist and there really isn't any caregiver input into the process. When the PACT team submits a referral, it's typically a one and done process. Dr. O'Toole indicated that this has resulted in a lot of built in inefficiencies.

The goal is to allow more Veterans who are aging and have complex needs to be able to choose home and community services over nursing home placement. The Choose Home Approach is divided into 3 lines of action: 1.) Developing a clinical platform and delivery model and focusing on precision; 2.)

Enhancing efficiencies and accountability; and 3.) Strengthening community partnerships and capacity for navigation and being driven by evidence based research platform.

Moving forward the Choose Home Initiative will focusing on:

1. Identifying the individuals in need, Dr. O'Toole worked with GEC DAC to create a predictive analytic model to help identify the individuals who are at highest risk for being placed in a nursing home or dying in the next two years. There are currently about 21k Veterans in this predictive model. This data is being converted into a dashboard to help provide an accurate denominator for the demand of these specific services.
2. Looking at the processes of care, Dr. O'Toole wants to identify how to get people into different areas of care. His team is currently launching a request for proposals and participation in a pilot that will improve the referral process using a standardized assessment and provide comprehensive community coordination care planning for those who are in need of non-institutional care.
3. Dr. O'Toole hopes to have a one-click referral process for multiple sources that would go to a choose home interdisciplinary assessment team that would be able to conduct an assessment that would be relative to the continuum of non-institutional care programs.
4. Looking at the culture of care, VA can't build a better system without looking what is in the system. There is currently a pilot going on in 3 VISNs to develop a caregiver funded curriculum to help enhance the communication and capacity to incorporate that perspective. The Office of Whole Health will be teaming with Choose Home to implement the system once it is developed.
5. Feedback and accountability. Working on creating a business model to help facilities and hold them accountable. Selected to be a recipient site for evidence based synthesis program. This is an initiative ran by QUERI where they will do a deep dive into literature of nursing home placement.
6. Working on developing a VISN and facility metric to determine the impact of Choose Home and how it affects the average length of stay in nursing homes for Veterans.
7. Promoting an evidence based approach through a Center of Excellence that was identified on September 7<sup>th</sup>, entitled Elizabeth Dole Center of Excellence for Caregiver Research. It is a 5-center consortium based out of San Antonio.

Dr. O'Toole believes this approach would lend itself to a Veteran specific care management process moving forward. The hope is to streamline the process and create greater efficiencies within the system on how Veterans can be better engaged.

Dr. O'Toole asked for feedback on the approach moving forward. Several comments were made about the name, "Choose Home" because it implies that we are telling the Veteran to choose the home without giving them the option to make the decision for themselves. Dr. O'Toole indicated that the name, and any changes that have occurred since its implementation, came from levels above his paygrade. Dr. Beizer commented that she really likes the approach of working with interdisciplinary teams. Ms. Gerhard applauded the efforts on developing a predictive analytic model since this is an issue they face quite a bit in the Long Term Services and Supports (LTSS) arena. Dr. Ouslander cautioned Dr. O'Toole's team to

consider the unintended consequences of Choose Home, such as the stress and other health effects that can be put onto caregivers. Ms. Hansen commented that length of life alone is not the ultimate outcome and encouraged breaking out the level of complexity in the data they have put together. Dr. Gifford agreed that person centered care is important and that quality of life vs length of life may be a more appropriate measure.

**Nicole Katikos**  
**VHA Workforce Services**

Ms. Nicole Katikos, MHA met with members to provide updates since the last face to face meeting. Previously, Ms. Katikos spoke with members about the implementation of VHA's new Manpower Management Office, the lack of standardized accounting for the workforce in terms of nurses and physicians, and a trainee hiring event they were in the midst of for mental health.

VHA's Manpower Management Office was stood up in July 2018 and Ms. Katikos is currently the Acting Director of the new office. There will be 17 FTE with 4 functional areas:

1. Workforce Planning Requirements
2. Staffing Models – using workload and patient volume and other metrics of demand look at the services each health care system needs to determine an expected amount of FTE that should be seen at each Health Care System (HCS) to provide a service.
3. Resources Management – putting in place a standard organizational structure, starting with VHACO and then working with the facilities to do the same.
4. Manpower Information Systems of Manpower – ensuring every VA staff member is in the personnel system coded and identifiable in a standardized way.

Almost 20 percent of VA's nurse practitioners work in a long-term care setting - the numbers pulled previously on this was closer to 4 percent, so VA is already getting a better idea of the workforce. Next, a list of physician assignment codes is being completed and the plan is to implement them next year.

The Annual Staffing Shortage exercise was completed. CLC inpatient nurses were identified as a shortage specialty. Geriatric physician positions were just outside of the top 10 areas of shortages. One third of VA nurses are eligible to retire. The nursing workforce is ageing out and this trend is also being seen in the private sector. In VA, less than 1 percent of nurses are under the age of 30. The Office of Nursing Services has a proposal to expand a program, "RN Transition to Practice." This program takes new nurse graduates and puts them through a preceptor program to transition them to practice. A fair amount of facilities have this program, however, there are not enough preceptors available to increase the volume of nurses that can be put through the program.

The current amount of time it takes to hire VA nurses is under 120 days – this does differ from HCS to HCS. Delays typically are a result of the hiring manager and the front end of the recruitment process. VA turnover is pretty low compared to the private sector and other Federal agencies (sitting at roughly 9 percent and has been that way for 17 years). There are specific facilities that have higher turnover rates than others, however, they are outliers. There are special pay tables that CLCs can use to deal with high turnover of CLC nurses.

Determining how many people VA needs is being determined by an office called Enrollee Forecasting. This office looks at enrollees and reliance, and estimates the resources and demand that is going to drive

future staffing needs. Work force management is still working on how this information can be used to project staffing requirements to meet the anticipated demand.

The Mental Health Trainee Event performed marketing for 6 days and 2,050 individuals completed some part of the registration. It was for trainees and early career professionals. Eighty-five health care systems participated out 140. There were 871 positions available and 1,400 people were eligible to be matched. There were 800 meet and greets, 200 job interviews, and 100 tentative job offers. So far 75 offers have been accepted. This event was very successful for psychologists and social workers. There was a small number of RNs registered. Workforce management is thinking about doing this again for psychologists shortly. They found this event a great way to connect a large volume of applicants with employers.

#### **Stephen Thielke, MD and Sherri DeLoof, LMSW GRECC Issues**

Dr. Stephen Thielke and Ms. Sherri DeLoof briefly reviewed the contents in the GRECC 2017 Annual Report and opened it up to members for questions. Dr. Thielke indicated that there is going to be a new database moving forward to capture grants, expenditures, and publications that will create a consistent calculation of the efforts. They expect that the system will have to be tweaked in the first year, but the goal is to shore it up. Ms. Gerhard suggested that the GRECC program staff work with a VHA communications team to broadcast the good news stories. Ms. DeLoof noted that 10 of the 20 GRECCs distribute newsletters quarterly to highlight the work that they do. These newsletters are posted on the GRECC website.

Dr. Cohen asked what the current VA leadership wants from the GRECCs. Dr. Thielke clarified that the Medical Centers fund the GRECCs. Dr. Thielke has instructed the GRECCs to have them work with their VISN and Medical Center leadership for direction. It is time to renew annual MOUs and this year the MOU was reshaped requiring the GRECCs to identify what they are going to do for their Medical Center and vice versa. Ms. Gerhard emphasized the importance of external partnerships. She believes there is a larger audience that isn't aware of the work GRECCs are doing and messaging GRECCs as a national asset needs to happen at the national level. This can be used to advocate the continued existence of GRECCs and keep them moving into the future needs and highlight the value they are bringing. Dr. Gifford emphasized that the messaging needs to come from VA Central Office to the VISNs.

Dr. Thielke and Ms. DeLoof briefly reviewed the GRECC maps that identify the different focus areas of each GRECC. Dr. Ouslander asked how often GRECCs are encouraged to disseminate information to each other. Ms. DeLoof indicated dissemination is constantly encouraged.

Dr. Thielke provided some background of how new GRECCs are established. The regulation that set up the GRECCs allows up to 25 and there are currently 20. SECVA must approve the establishment of a new GRECC. If a GRECC is stood up, VACO funds it for 3 years, then the Medical Center is expected to support. Members discussed the idea Dr. Fuller has of establishing a new GRECC focusing on Long Term Care. Dr. Gifford mentioned that he believes the award for the new GRECC shouldn't go to the best applicant – it should go to the applicant that meets the needs.

#### **Problem GRECCs:**

1. Minneapolis GRECC has not had a director for over 4 years, however, a job offer has been made to fill the position.

2. Eastern Colorado Health Care System (ECHCS) is the newest GRECC, launched in 2016 (?) and is struggling due to competing priorities at the local VAMC. They are having issues filling their FTE. ECHCS will have a special site visit to follow up in FY19. Dr. Gifford commented that the pressure for GRECCs to perform well should be through the VISN and Medical Center and not directly on the GRECC. Some of the challenges appear to be external to the GRECC. The VISN and Medical Center is not making their GRECC a priority. The Chair recommended that site visit members meet with the leadership at the beginning of the meeting to find out how they are supporting the GRECC and then end the meeting with leadership to follow up with the results of the site visits.
3. Greater Los Angeles (GLA) GRECC was the result of the combining of the West LA and Sepulveda GRECCs in (what year?) At that time the combined total FTE was 28. The VISN did not want to support 28 FTE and requested to downsize to 12. This request was reviewed by the Under Secretary for Health (USH) and GEC in which GLA was approved to reduce their FTE from 28 to 20. GEC sent a request to GLA to gain a better understanding of the situation and received a response from the MCD indicating that the GRECC is meeting its performance measure with the current FTE of 16.5 and as a result, there are no plans to fill any vacancies. Members asked about the minimum standard for FTE. Each GRECC is funded for 12 FTE initially, then they need to negotiate an increase in the number of FTE as needed with the MCD. The GRECC handbook recommends a minimum of 12 FTE. Members questioned what the right number is and indicated that this is a unique situation. GEC staff mentioned that programs will be lost if FTE are not filled, however, Dr. Cohen reminded members that services are not the function of the GRECC - services are the function of the GEC program office. If it's not research, education, or clinical demonstration it is going to be difficult to argue the need for the full 20 FTE. GGAC accepts their response to keep it at 16.5 FTE. The Chair recommended that GEC, leadership, and the MCDs get together and discuss it. The number of FTE needs to be revisited by USH leadership to determine what the appropriate number of FTE should be. GGAC does not feel they need to go up to 20.
4. New England is a two-site GRECC (Bedford and Boston) that has struggled to work in concert. During the last site visit in 2016 there was optimism that with the hiring of Dr. Jonathan Bean the sites would be better able to coordinate communications and activities. However, a functional productive single unit from the two sites has remained elusive. A memo from GEC was issued in June 2018 notifying them that they are not in compliance with the GRECC Handbook because they have 4 vacant FTE at the Bedford GRECC site and the structure of the GRECC leadership may not be divided between sites. The New England GRECC is supposed to be at 24 FTE and Bedford wants to go down to 6 FTE. There are currently 19.5 FTE total at the New England GRECC. GGAC indicated that the ultimate decision would fall on VHA leadership, however, GGAC's recommendation to Dr. Fuller is to focus resources at the Boston site. The FTE level of the Boston GRECC should be negotiated with the Medical Center (who will then negotiate it with the USH). GGAC commented that the VA should follow whatever process or timeline deemed appropriate.

**Ms. Alejandra Paulovich, DFO, GGAC**

**FY 19 Site Visits, FY 19 F2F Meetings, Committee Membership**

Admiral Clyde Marsh notified committee members that he accepted a position with the VA and will have to resign from the Committee. A special election was held and Dr. Gifford was elected as the new Chair for the Committee and Dr. Cohen as Vice Chair. They will serve a two-year term in these positions. A

meeting will be set up between the outgoing Chair, new Chair, and Vice Chair to ensure a seamless transition in leadership.

GGAC is scheduled to conduct site visits to Minneapolis, San Antonio, Salt Lake City, and ECHCS in FY 19. Ms. Paulovich will follow up with final dates and issue a call for site visit volunteers in the near future. There was a discussion about the structure of the site visits. Ms. Paulovich will send out the memo and questions that set the structure and provide the read-ahead materials for GGAC site visitors to members so they can provide feedback and suggestions for changes.

The next face to face meeting will be held on April 10-11, 2019.

Ms. Paulovich went over the committee membership and identified memberships that will expire in the coming year. Ms. Paulovich will follow up with the identified individuals to process the appropriate membership renewal package.

### **Committee Discussion and Recommendations**

Members discussed recommendation #8 to SECVA from 2017 on setting up a Long-Term Services and Support (LTSS) Intergovernmental task force. The intent of the task force was for collaboration to occur among intergovernmental agencies at the Federal, state, and local level. The recommendation was for a group to formally be stood up and meet regularly. GEC received feedback from leadership on this recommendation and indicated that leadership wanted to house this taskforce as a subcommittee under GGAC.

GGAC members also reviewed material from the previous day and came up with the following recommendations for SECVA:

1. GGAC would like to provide clarification on their recommendations to SECVA in 2017. GGAC's recommendation to establish an LTSS taskforce was never intended to be a GGAC driven initiative. The GGAC recommendation was for VA to take the leadership in establishing and running this taskforce.
2. Geriatric, Research, Education, Clinical Centers (GRECC)
  - a. The Under Secretary for Health issued a memo to the New England GRECC in June 2018 notifying them that they are not in compliance with the GRECC Handbook due to inadequate FTE staffing at the GRECC site. The New England GRECC is supposed to be at 24 FTE, however, they are currently at 19.5 FTE. GGAC recommends deactivation of the Bedford site and that the FTE level of the Boston GRECC be negotiated with the Medical Center and VHA leadership.
  - b. The Greater LA GRECC had previously been located at two sites. When the sites combined the sites ended up with 28 FTE. The Medical Center does not want to support 28 FTE and has requested to downsize to 12. This request was reviewed by the GEC program office and it was found that there is an agreement in place for the Greater LA to have 20 FTE. The Greater LA GRECC is currently staffed at 16.5 FTE. GGAC recommends GEC leadership, VISN 22, and the Greater LA Medical Center Director determine the adequate staffing level for the Greater LA GRECC.
  - c. GGAC recommends VA leadership develop a mechanism to internally and externally promote the great work that is being conducted within the GRECCs. GGAC believes it is

- important to highlight their value. GRECCs are a national asset and this messaging needs to occur at the national level.
- d. GGAC concurs with Dr. George Fuller's proposal to establish a new GRECC with a national focus on long term care.
  3. GGAC recommends that the Whole Health with Choose Home programs be aligned.
  4. The geriatric cohort is, and will continue to be, the costliest cohort for VA. This population is expected to grow exponentially with the aging of the Vietnam era Veterans. GGAC recommends VA leadership utilize data from GEC's Data Analysis Center and the Veterans Equitable Resource Allocation model for purposes of projecting the needs and future demand of VA services. This data should be used for the planning in different programs areas, including but not limited to, Human Resources planning, GRECC selection, GEC Expansion, VISN prioritization and sharing. This information should be regularly shared with VA leadership to calculate appropriate GEC service allocation.
  5. GGAC supports Dr. Richard Stone's focus on restoring trust in VA, his intent for VA becoming a better learning organization, and his efforts towards implementing modernization across VHA. As VA moves forward in executing Dr. Stone's top 3 visions, GGAC recommends that the principles from the Whole Health and Choose Home initiatives are included during the discussions and decisions related to VHA's reorganizational efforts. GGAC supports the approach of restructuring VHA towards a horizontally integrated organization, however, it is important to balance the principles held within these programs to meet the needs of Veterans.
  6. GGAC recommends VA leadership establish an external CLC Quality Work Group to examine the quality of VA CLCs. The work group should be composed of LTC experts who are not affiliated with VA systems but who are knowledgeable regarding VA long term care. The CLC Quality Work Group should include research on unique populations and the acuity of Veterans in CLC's compared to state veteran homes and other state nursing facilities. Additionally, GGAC encourages VA to invite Congressional leaders to visit VA CLCs to witness, first hand, VA's resident acuity, environment, and care delivery.

  
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Admiral Clyde Marsh  
Chairman  
Geriatrics and Gerontology Advisory Committee (GGAC)

Date 10-26-18